LOOP Smiles

ABOUT YOU

Today's Date: ____________________

First Name: ____________________

Last Name: ____________________

SS#: ____________________

Birthdate (mm/dd/yyyy): ____________________

Age: __________ ☐ Male ☐ Female ☐ Gender Neutral

Home Address: ____________________

City: ____________ State: ______ Zip code: ________

Cell #: ____________________

Email Address: ____________________

How do you prefer to be contacted? ☐ E-Mail ☐ Phone ☐ Text

Employer:

Occupation:

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Other family members seen by us: ____________________

Previous / Present Dentist: ____________________

Last Visited Dated: ____________________

How did you find out about us?

☐ Google ☐ ZocDoc ☐ Yelp

☐ Friend ☐ Facebook ☐ Other

Whom may we Thank for referring you? ____________________

SPOUSE INFORMATION

His / Her Name: ____________________

Employer: ____________________

SSN#: ____________________

Birthdate (mm/dd/yyyy): ____________________

Person responsible for account: ____________________

Cell#: ____________________

Relation: ____________________

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone #: ____________________

Group #(Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Insured's Birthdate: ____________________

Insured's ID #: ____________________

Insured's Employer: ____________________

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: ____________________

Insurance Co. Address: ____________________

Insurance Co. Phone#: ____________________

Group #(Plan, Local or Policy #): ____________________

Insured's Name: ____________________

Insured's Birthdate: ____________________

Insured's ID #: ____________________

Insured's Employer: ____________________

EMERGENCY CONTACT

His/ Her Name: ____________________

Relation: ____________________

Cell #: ____________________

WK#: ____________________

CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: ______________________________

Phone#: ______________ Date of late visit: __________

Are you currently under the care of a physician? Yes ☐ No

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one : ______________________________

____

____

Have you ever taken Fosamax, or any other bisphosphonate?

☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Wk #:____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

☐ Abnormal Bleeding	☐ Alcohol / Drug Abuse
☐ Anemia	☐ Arthritis
☐ Artificial Bones/Joints/Valves	☐ Asthma
☐ Blood Transfusion	☐ Cancer /Chemotherapy
☐ Colitis	☐ Congenital Heart Defect
☐ Diabetes	☐ Di_culty Breathing
☐ Emphysema	☐ Epilepsy
☐ Fainting Spells	☐ Frequent Headaches
☐ Glaucoma	☐ Hay Fever
☐ Heart Attack	☐ Heart Murmur
☐ Heart Surgery	☐ Hemophilia
☐ Hepatitis	☐ Herpes / Fever Blisters
☐ High Blood Pressure	☐ HIV + / AIDS
☐ Hospitalized for Any Reason	☐ Kidney Problems
☐ Liver Disease	☐ Low Blood Pressure
☐ Mitral Valve Prolapse	☐ Pacemaker
☐ Psychiatric Problems	☐ Radiation Treatment
☐ Rheumatic / Scarlet Fever	☐ Seizures
☐ Shingles	☐ Sickle Cell Disease
☐ Sinus Problems	☐ Stroke
☐ Thyroid Problems	☐ Tuberculosis (TB)
☐ Ulcers	☐ Venereal Disease

DENTAL HISTORY

Why have you come to the dentist today?

____

____

____

____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: : ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would like whiter teeth ☐ Yes ☐ No

Fresher breath? ☐ Yes ☐ No

How many times a week do you floss?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

____

Signature date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductibles that my insurance does not cover.

____

Signature date